Coventry Health Care of Delaware, Inc. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Optimum Choice, Inc. MD-Individual Practice Association, Inc. CareFirst BlueChoice, Inc. CIGNA HealthCare Mid-Atlantic, Inc. Aetna Health Inc.—Maryland, DC, and Virginia

Maryland Health Care Commission

Coventry Health Care of Delaware, Inc. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. CIGNA HealthCare Mid-Atlantic, Inc. Aetna Health Inc.—Maryland, DC, and Virginia Optimum Choice, Inc.

Measuring the Quality of Maryland HMOs and POS Plans

2006

STATE EMPLOYEE GUIDE

MHCC MARYLAND HEALTH CARE COMMISSION

ABOUT THE MARYLAND HEALTH CARE COMMISSION (MHCC)

The MHCC is a public, regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary charge of the Commission is to evaluate and publish findings on the quality and performance of commercial HMOs, nursing homes, hospitals, and ambulatory surgery facilities that operate in Maryland. MHCC produces this Guide annually with the cooperation of Maryland HMOs and their members. Additionally, MHCC coordinates efforts with the Office of Personnel's Employee Benefits Division to provide this Guide to State employees. These annual performance reports are the only source of objective, independently audited information on the quality of Maryland commercial HMOs. More information about MHCC and performance reports is available at **http://mhcc.maryland.gov/consumerinfo/**.

Measuring the Quality of Maryland HMOs and POS Plans: 2006 State Employee Guide is published by the Maryland Health Care Commission.
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-3460; Fax: 410-358-1236; Toll-Free: 877-245-1762; TDD: 800-735-2258
Web site: **http://mhcc.maryland.gov**

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ABOUT THIS GUIDE

Choosing a health plan is one of the most important decisions you can make. Because all health plans are not the same, the one you choose can make a difference in the quality of your health care. *Measuring the Quality of Maryland HMOs and POS Plans: 2006 State Employee Guide* compares managed care plans in Maryland on the quality of care and service they provide. You should use the information provided in this Guide along with cost and benefit information in the *2006 State of Maryland Summary of Health Benefits* book supplied by the Office of Personnel's Employee Benefit division to make a decision about your health care. Be an informed consumer when it comes to your health care.

Who should read this Guide?

Maryland *State* employees choosing a health plan—use this Guide to make an informed choice by comparing the quality of the health maintenance organizations (HMOs) and point-of-service (POS) plans available to you. In 2006, State employees will have the same health plan options as in 2005.

Maryland *State* employees who already have a plan—use this Guide to learn more about making the best use of your health plan.

What you can learn from this Guide:

- how HMOs and POS plans work
- how health plan members rated their plans' services
- how well plans provided important health care services, tests, and treatments
- tips on taking care of your health
- steps to take if you disagree with your plan's decision to limit or deny medical services
- plans' service areas, customer service hours, and telephone numbers

Safeguard Your Health

HEALTH CHECKS FOR ADULTS

Regular tests—screenings—for diseases like cancer and diabetes will help you find them early, often before you have symptoms. Along with eating a well-balanced diet and exercising, make screenings an important part of your healthy living activity. By finding a problem early you improve your chances of getting better, and may even save your life.

Your doctor will recommend tests or screenings based on your:

- age and gender
- current health
- medical history
- family history

Your doctor may want you to get some tests sooner or more often than other tests if you have a risk for a certain illness. You should talk to you doctor about testing for:

- diabetes
- high blood pressure
- high cholesterol
- vision and hearing
- cancer (skin, colorectal, breast, and other types of cancer)
- tuberculosis

PREVENTING ILLNESS IN CHILDREN

Immunizations (shots) are very important in preventing illness in children. By getting your child the recommended shots, you can prevent diseases like chicken pox, mumps, measles, and illnesses like the flu. If your child does not get the recommended shots, he or she may get very sick and cause other children to get sick. For example, whooping cough is a highly contagious disease that causes coughing spells and choking, which makes it hard for children to breathe, or can cause death. The number of people getting this disease has increased 63 percent from 2003 to 2004 as a result of infants and adolescents not receiving their shots (CDC, 2005).

Keeping track of which shots your child needs can be difficult. Maryland doctors can keep your child's shots up to date using **ImmuNet**. ImmuNet is a computer system that helps doctors track immunizations given to children. Your information is kept private and safe. Although only doctors can access this system, there are many benefits to you and your child.

ImmuNet helps your doctor keep your child healthy by:

- making sure that your child receives correct and timely immunizations;
- providing Maryland doctors access to your child's complete shot history so that if you move your new doctor will have the information;

STAYING HEALTHY AT ANY AGE

■ GET SCREENING TESTS ■
■ PRACTICE HEALTHY BEHAVIORS ■
■ GET IMMUNIZED ■

MEN | What You Need & When

Cholesterol Checks: Check your cholesterol every 5 years starting at age 35. Start at age 20 if you smoke, have diabetes, or if heart disease runs in your family.

Prostate Cancer Test: Ask your doctor about the benefits and risks of having this test. Know your risk—father or brother had this illness, high fat diet, African-American, over age 50.

WOMEN | What You Need & When

Mammogram: Have this test every 1 to 2 years starting at age 40.

Pap Smear: Have this test every 1 to 3 years if you are age 21 or earlier if you are sexually active.

Cholesterol Checks: Check your cholesterol starting at age 45. Start at age 20 if you smoke, have diabetes, or if heart disease is in your family.

Osteoporosis Tests: At age 65 check the strength of your bones. Ask your doctor about checking earlier, ages 60 to 64, if you weigh 154 lbs. or less.

Chlamydia Tests: Check for this illness if age 25 or younger and sexually active. If older than 25, talk to your doctor about whether you need the test.

- tracking your child's shot records from different doctors so your child does not get a shot more often than needed; and
- sending you a reminder when your child is due for a shot.

For additional information on ImmuNet visit the registry Web site at **www.mdimmunet.org**.

USE OF ANTIBIOTICS

Antibiotics are drugs that fight infections caused by bacteria. When used correctly, antibiotics reduce deaths and length of illness from infections. Yet today, many commonly used antibiotics do not work against the germs they were designed to kill. This is because each time you take an antibiotic when it is not needed (for example, for an infection from a virus) or use an antibiotic improperly (for example, not taking all the pills you were prescribed), your body can develop more powerful germs—"super bugs"—that can be difficult to treat. Then, in a situation where you really need an antibiotic, it may not work as effectively because the infection has become *resistant* to treatment. This is called **antibiotic resistance**.

The Do's and Don'ts to preventing antibiotic-resistant infections:

- **Do** use antibiotics *only* when your doctor prescribes them.
- **Do** take *all* of the antibiotics prescribed. Even when you feel better, you may still have infectious bacteria in your body that could make you sick again.
- **Do** check with your pediatrician to confirm that your children's immunizations are up to date. This important step will help your family fight disease.
- **Do** wash your hands thoroughly and often to help prevent illness and the spread of germs (antibiotic-resistant bacteria).
- **Don't** take antibiotics prescribed for someone else or save some of the prescription for the next time you get sick.
- **Don't** pressure your doctor to prescribe antibiotics to treat symptoms of a cold, flu, or other viral illness (Centers for Disease Control and Prevention, 2005).

MEN and WOMEN | What You Need and When

Blood Pressure: Check at least every two years.

Colorectal Cancer Tests: Begin regular screening for this type of cancer at age 50. Your doctor will help you decide the right test for you.

Diabetes Tests: When you have high blood pressure or high cholesterol ask your doctor to check for this illness.

Depression: Talk to your doctor about a screen if you have felt sad or hopeless and do not have interest or pleasure in doing things for two weeks straight.

Sexually Transmitted Diseases: Ask your doctor about whether you should have a test for diseases, such as HIV.

■ DON'T SMOKE ■
■ EAT HEALTHY ■
■ STAY ACTIVE ■
■ KEEP A HEALTHY WEIGHT ■

IMMUNIZATIONS

You should:

- have a flu shot every year starting at age 50.
- have a tetnus-diptheria shot every 10 years.
- have a pneumonia shot once at age 65 (earlier if you have certain lung diseases).
- talk to your doctor to see if you need hepatitis B shots.

Source: Agency for Health Care Research and Quality, 2005

Managed Care in Maryland

MARYLAND HEALTH PLANS IN THIS GUIDE

This Guide reports on the three HMOs and two POS plans licensed under HMOs offered to State employees. See page 23 for more details about HMO and POS products. In total, seven commercial HMOs report information on their quality to MHCC. Ratings are calculated using the results of all seven plans. Results for all of the plans, except Kaiser Permanente, use data collected from the HMO and POS products. Kaiser Permanente's ratings are based on data from its HMO product only.

Quality information on the CareFirst BlueCross BlueShield POS plan, *Maryland Point of Service*, is not reported in this Guide. MHCC does not require CareFirst BlueCross BlueShield to submit quality information on the POS plan it administers for State employees due to the plan's licensing arrangement, which makes it exempt from reporting.

The table below shows the number of members enrolled in 2004 and the percentage of total members who chose to enroll in the product. POS products tend to cost more, which may explain why fewer people selected the POS product.

TRENDS IN MANAGED CARE

- Nationally, health care insurance premiums have risen steadily over the years: 13.9 percent from 2002 to 2003; 11.2 percent from 2003 to 2004. To offset their expenses, employers often increase employees' share of the costs (deductibles, copayments, coinsurance). The trend in cost sharing continues in 2005, although to a lesser degree than in the past (Health Affairs, 2005).
- Enrollment in managed care plans (HMOs, PPOs, POS plans) nationally has risen dramatically, from 27 percent in 1988 to 95 percent in 2004. This growth has been largely driven by PPO enrollment, which rose from 11 percent in 1988 to 55 percent in 2004. HMO enrollment has been less consistent, increasing to 31 percent in 1996 but decreasing to 25 percent in 2004. The shift from traditional managed care (HMOs) to PPOs may reflect consumers' preferences for fewer restrictions on access to care (Kaiser Family Foundation, 2004).
- Rising costs and movement toward simpler access have led employers and plans to encourage consumers to become more involved in their health care. This means they must be more knowledgeable, accountable, and active in managing their care. As active partners in their health care, consumers will:
  - use their health care benefit dollars wisely by choosing cost-effective services and quality providers;
  - take control of their health care needs by actively seeking information about conditions and participating in risk-management programs;
  - make informed decisions about care and consider the resources needed to provide that care; and
  - gain confidence in their decisions (Mercer, 2004).

Enrolled in Product	Number of Plan Members	% of All Members Enrolled in Product
HMO		
CareFirst BlueChoice, Inc. **(BlueChoice)**[a]	494,693	56%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. **(Kaiser Permanente)**[b]	444,088	97%
Optimum Choice, Inc. **(OCI)**[c]	521,886	82%
POS		
Aetna Health Inc.—Maryland, DC, and Virginia **(Aetna)**	337,317	13%
MD-Individual Practice Association, Inc. **(M.D. IPA)**[c]	243,659	15%

a **BlueChoice**, a for-profit HMO, operates under a holding company called CareFirst.
b **Kaiser Permanente's** performance in this Guide relates to HMO members only. It is the only non-profit HMO operating in Maryland.
c Two for-profit HMOs, **M.D. IPA** and **OCI**, are owned and operated by **Mid-Atlantic Medical Services, LLC (MAMSI)**, a regional holding company and subsidiary of UnitedHealthGroup, Inc.

Understanding Quality

MEASURING THE QUALITY OF HEALTH PLANS

We all have ideas about what we expect from our health plan. In general, most people want services that fit their own health care needs and give the best results. It is not possible to measure everything you may want to know about health plans, but the information that is available can tell you a lot. For example:

- Does the health plan provide members with important preventive care, early testing, and treatment so that problems don't become more serious?
- Would members recommend the plan to their family and friends?
- Can health plan members get services and care when they need it?

This Guide covers many areas that are important for you to know about.

DATA SOURCES

Information in this Guide was gathered from Maryland plans and from members of the plans. Data (rates) included here are not specific to Maryland State employees, but reflect the care provided to and the opinions of a sample of all members enrolled in the plans.

Member Survey: This symbol indicates that the information was gathered from health plan members using a survey that asked about their experiences with the plan. An independent company hired by the State conducted the survey of 1,100 members from each plan.*

Health Plan Records: This symbol indicates that the information was obtained from plans' records using a uniform system for collecting and reporting clinical information. All the HMOs collected their information in the same way. An independent company hired by the State checked plans' methods for accuracy.**

* The survey is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS® 3.0H). CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

** Health plans report data using a system called the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® is a registered trademark of the National Committee for Quality Assurance.

LOOK FOR THESE SYMBOLS

In the Guide, the following symbols are used to rate plans on 33 different measures of care and service:

✪ This symbol stands for **Star Performer**. It means that the plan's performance was better than the Maryland average for three years in a row (2003, 2004, and 2005).

● This symbol means that the plan's performance was **better than** the Maryland average.

◓ This symbol means that the plan's performance was **equal to** the Maryland average.

○ This symbol means that the plan's performance was **worse than** the Maryland average.

The Maryland average for each measure of service is calculated from the results of the seven plans required to submit reports to MHCC.

SUMMARY OF PERFORMANCE

By adding each plan's ratings throughout this Guide, the table below shows the number of times plans were Above Average (symbol= ●) or Star Performers (symbol= ✪). Every plan had at least one Above Average rating. The highest number of times a plan could be a Star Performer is 25.

BlueChoice reports that rate increases above those reported in 2004 reflect improvements in data collection, enhancements to the disease management program, and actual measure specification changes.

Health Plan	Number of Times Above Average	Number of Times Star Performer
Aetna	1	0
BlueChoice	8	0
Kaiser Permanente	15	10
M.D. IPA	8	4
OCI	5	0

Members' Satisfaction With Their Health Plan

SUMMARY

The circles on this page summarize how members rated their health plan on the services they received. Bar graphs show plans' scores for each area. Higher than average scores mean better plan performance.*

Health Plan	Rating of Health Plan	Recommending Plan to Friends/Family	Few Consumer Complaints	Health Plan Customer Service
HMO				
BlueChoice	◓	◓	◓	○
Kaiser Permanente	◓	●	◓	◓
OCI	◓	◓	◓	◓
POS PLAN				
Aetna	○	○	◓	◓
M.D. IPA	●	●	◓	●

See below for averages, individual scores, and descriptions of these measures.

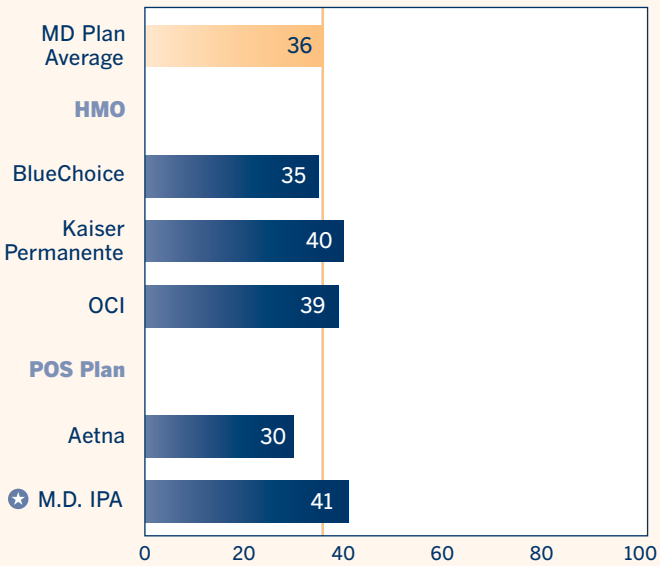
- ● **HIGHER** represents an **Above Average** score
- ◓ **AVERAGE** represents an **Average** score
- ○ **LOWER** represents a **Below Average** score

*Circles show statistically significant differences between each plan's score and the Maryland average. Statistically significant means scores varied by more than could be accounted for by chance.

DETAILS Member Survey

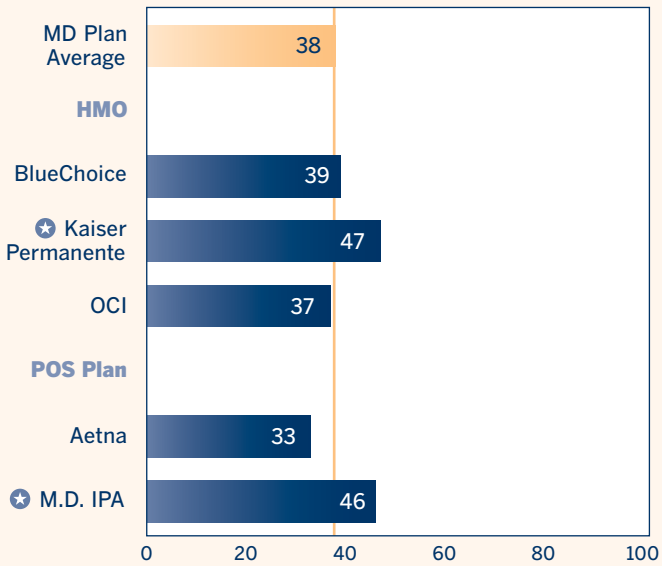
Rating of Health Plan

The percentage of members who rated **their** health plan "9 or 10" on a scale of 0–10, with 10 being the "**best health plan possible**."



Recommending Plan to Friends/Family

The percentage of members who said "**definitely yes**" when asked about whether they would recommend their health plan to family or friends.



MANAGE YOUR HEALTH CARE

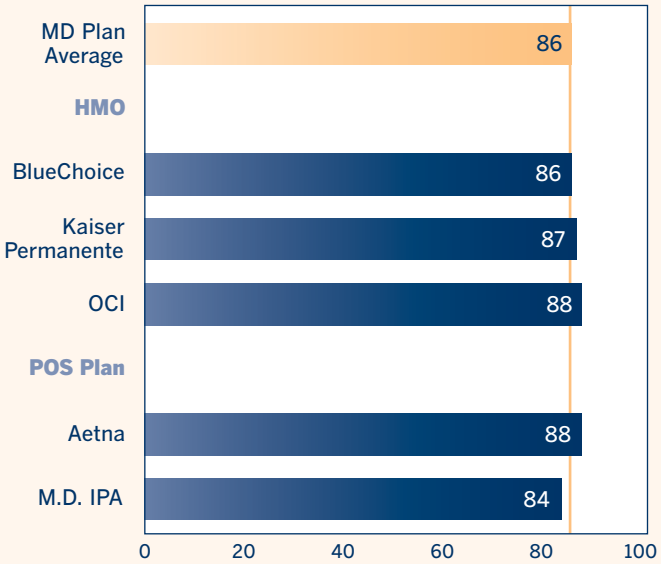
Your satisfaction with your doctor is an important aspect of your health care. Satisfaction can come from having a doctor who listens to your questions, explains things clearly, and whom you trust. If you are not satisfied with your doctor, contact your plan about how you can change your doctor.

On average, 91 percent of members in Maryland plans feel their doctor listened to them carefully, 93 percent said their doctor explained things clearly. However, 8 percent of members in Maryland plans changed their doctors once and 3 percent changed two times or more because they were not satisfied with the care they were getting.

✪ **STAR PERFORMER:** The plan's performance was above average for three years in a row.

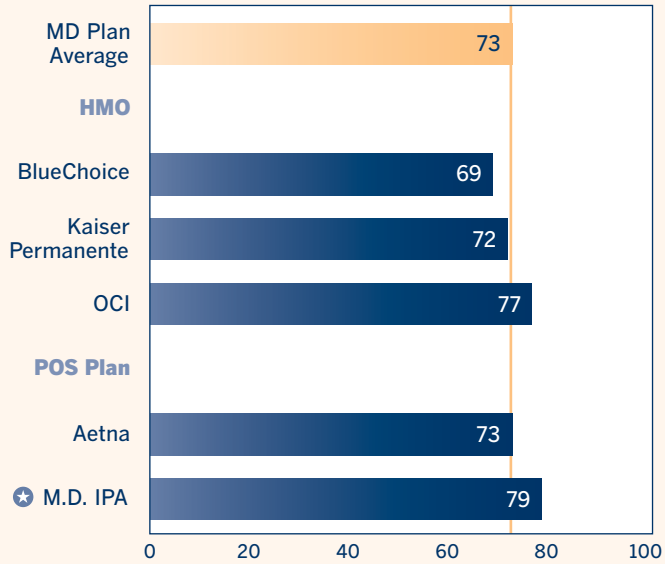
Few Consumer Complaints

The percentage of members who said they "**did not call or write their health plan with a complaint or problem.**"



Health Plan Customer Service

The percentage of members who said it was "**not a problem**" finding or understanding plan's information, getting help from their plan's customer service department, and filling out paperwork.



Members' Satisfaction With Getting Care

SUMMARY

The circles on this page summarize how members viewed their health care and the ease of getting access to care. Bar graphs show plans' scores for each area. Higher than average scores mean better plan performance.*

Health Plan	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Rating of Health Care
HMO				
BlueChoice	◓	◓	◓	◓
Kaiser Permanente	◓	◓	○	◓
OCI	◓	◓	●	◓
POS PLAN				
Aetna	○	◓	◓	◓
M.D. IPA	◓	◓	○	◓

See below for averages, individual scores, and descriptions of these measures.

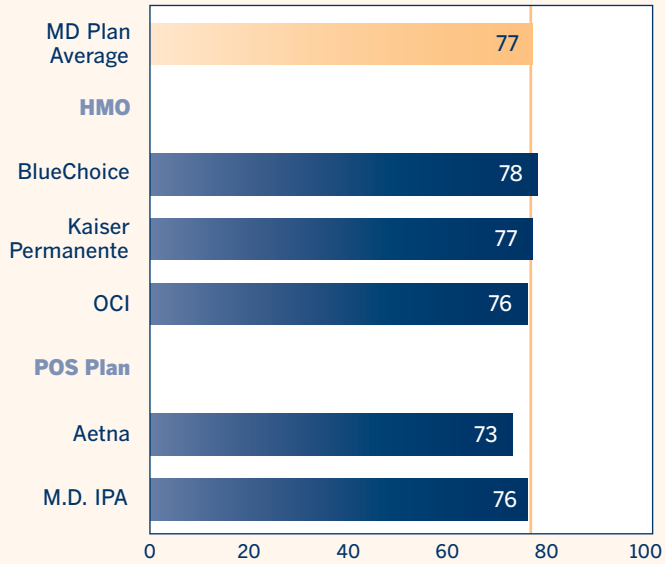
- ● **HIGHER** represents an **Above Average** score
- ◓ **AVERAGE** represents an **Average** score
- ○ **LOWER** represents a **Below Average** score

*Circles show statistically significant differences between each plan's score and the Maryland average. Statistically significant means scores varied by more than could be accounted for by chance.

DETAILS Member Survey

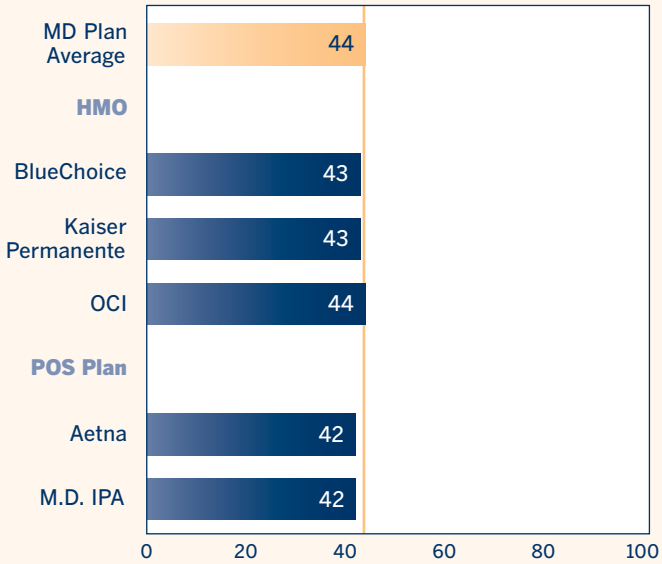
Getting Needed Care

The percentage of members who said it was "**not a problem**" selecting a personal doctor or nurse, seeing a specialist, receiving necessary care, and getting timely approval for care.



Getting Care Quickly

The percentage of members who said they "**always**" received help when they called their doctor during office hours, received care right away when needed, received timely appointments for routine sick or injured care, and waited no more than 15 minutes past their appointment time.



MANAGE YOUR HEALTH CARE

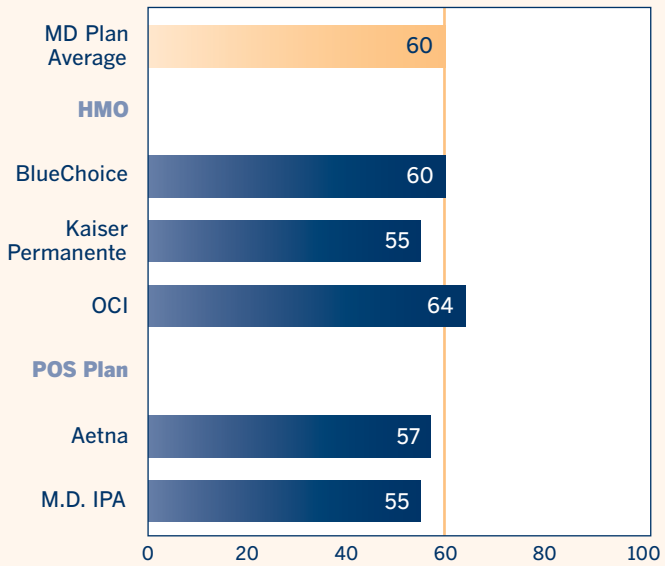
Smoking is the leading preventable cause of death in the United States. Smokers who quit, on average, live longer and have fewer years living with disability (U.S. Department of Health and Human Services, 2000). Quitting can also reduce the risk of smoking-related diseases, including lung cancer, heart disease, and chronic lung disease (Journal of the American Medical Association, 2000). Having your doctor assist you with quitting has shown to help improve the chances of succeeding. Get advice from your doctor on ways in which you can successfully quit smoking.

In response to a member survey, 73 percent of Maryland plan members ages 18 years or older, who were either current smokers or recent quitters, report receiving advice to quit smoking from their doctor.

✪ **STAR PERFORMER:** The plan's performance was above average for three years in a row.

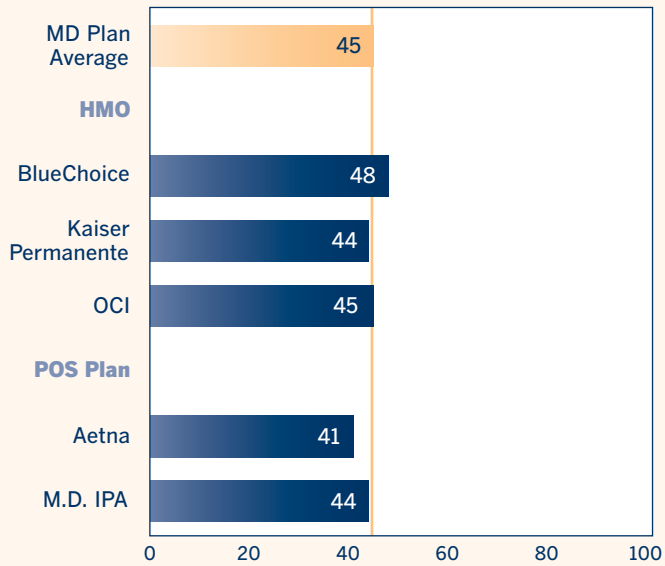
How Well Doctors Communicate

The percentage of members who said their provider "**always**" listened to them, explained things clearly, showed them respect, and spent enough time with them.



Rating of Health Care

The percentage of members who rated the overall care **they** received "9 or 10" on a scale of 0–10, with 10 being the "**best health care possible.**"



Children's Health

SUMMARY

The circles on this page summarize how well plans provided children with important preventive care services. Bar graphs show plans' scores for each area. Higher than average scores mean better plan performance.*

Health Plan	Immunizations for		Well-Child Visits for Infants and Children	Well-Care Visits for Adolescents	Appropriate Medicine for Children With Asthma
	CHILDREN	ADOLESCENTS			
HMO					
BlueChoice	◓	◓	●	●	●
Kaiser Permanente	●	●	○	○	○
OCI	○	○	◓	◓	◓
POS PLAN					
Aetna	○	◓	○	◓	○
M.D. IPA	◓	○	◓	◓	○

See below for averages, individual scores, and descriptions of these measures.

● **HIGHER** represents an **Above Average** score
◓ **AVERAGE** represents an **Average** score
○ **LOWER** represents a **Below Average** score

*Circles show statistically significant differences between each plan's score and the Maryland average. Statistically significant means scores varied by more than could be accounted for by chance.

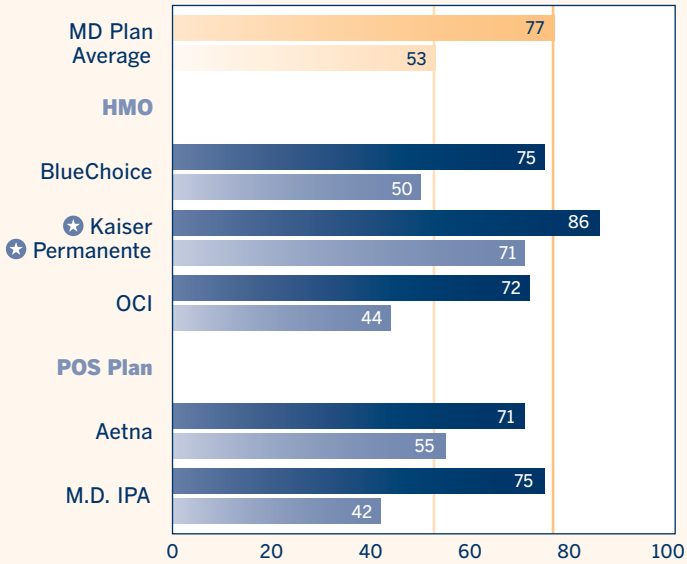
DETAILS Health Plan Records

Immunizations for Children and Adolescents

Percentage who received vaccines for:

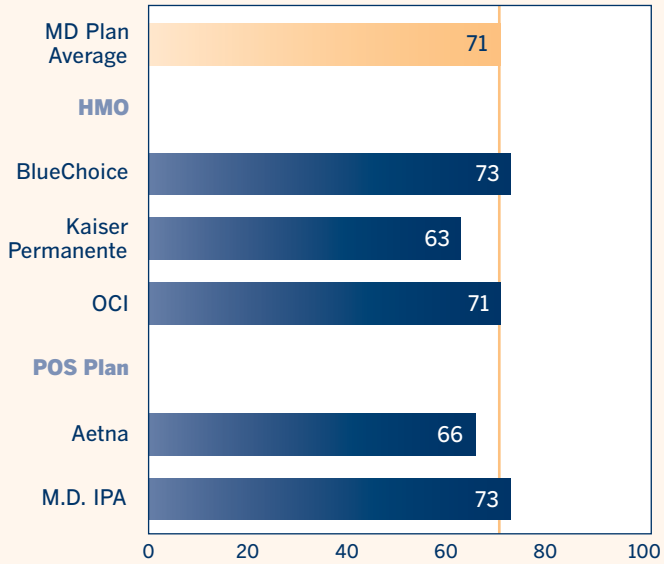
measles, mumps, and rubella (MMR); polio; influenza type b; hepatitis B; chicken pox (VZV); and diphtheria, tetanus, and pertussis (DTaP/DT) by age 2 years

measles, mumps, and rubella (MMR); hepatitis B; and chicken pox (VZV) by age 13 years



Well-Child Visits for Infants and Children

The combined percentages of infants who had 6 or more visits by age 15 months and children ages 3–6 who had at least one visit to a PCP during 2004.



MANAGE YOUR HEALTH CARE

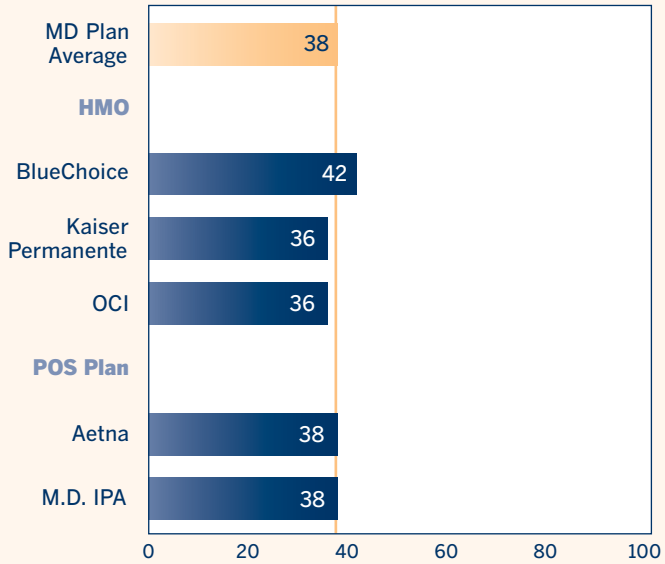
The number one reason that a child visits a doctor is for an ear infection. Most ear infections are caused by a virus or bacteria that can cause fluid to build up in the ear. Your doctor may only prescribe a pain reliever for your child for an infection from a virus. If the infection is caused by bacteria, your doctor may prescribe an antibiotic. It may become necessary for your doctor to place tubes in your child's ears if he or she has repeated ear infections or hearing loss due to infections. Each year, more than half a million ear tube surgeries are performed on children ages 1–3 years, making it the most common childhood surgery (AAO-HNS, 2004).

On average, 39 percent of children ages 0–4 years in Maryland plans had ear tube surgery. Although there is no proven way to prevent ear infections, talk to your doctor about the right treatment if your child gets an ear infection.

✪ **STAR PERFORMER:** The plan's performance was above average for three years in a row.

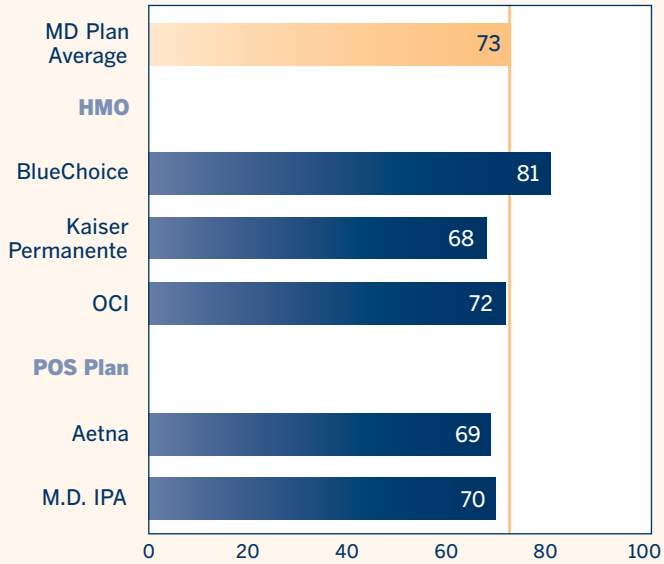
Well-Care Visits for Adolescents

The percentage of adolescents ages 12–21 who had at least one visit to a PCP during 2004.



Appropriate Medicine for Children With Asthma

The percentage of members ages 5–17 with persistent asthma who received inhaled asthma medicine (corticosteroids or one of three alternative therapies) in 2004.



Women's Health

SUMMARY

The circles on this page summarize how well plans provided their female members with important preventive care services. Bar graphs show plans' scores for each area. Higher than average scores mean better plan performance.*

Health Plan	Check-Ups for		Screening for Breast Cancer	Screening for Chlamydia	Screening for Cervical Cancer
	PREGNANT WOMEN	NEW MOMS			
HMO					
BlueChoice	●	◒	◒	○	◒
Kaiser Permanente	◒	●	◒	●	◒
OCI	○	○	◒	○	◒
POS PLAN					
Aetna	◒	◒	◒	○	◒
M.D. IPA	○	◒	◒	○	◒

See below for averages, individual scores, and descriptions of these measures.

● **HIGHER** represents an **Above Average** score
◒ **AVERAGE** represents an **Average** score
○ **LOWER** represents a **Below Average** score

*Circles show statistically significant differences between each plan's score and the Maryland average. Statistically significant means scores varied by more than could be accounted for by chance.

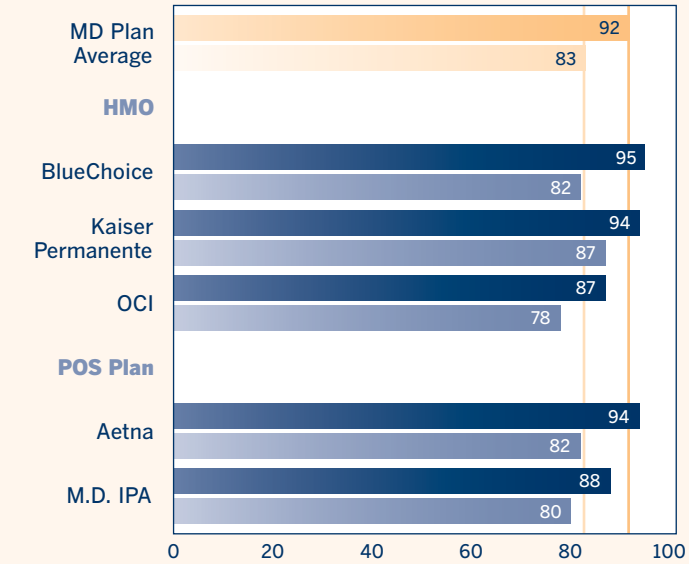
DETAILS Health Plan Records

Check-Ups for Pregnant Women (Prenatal Care) and New Moms

The percentage of women who gave birth and:

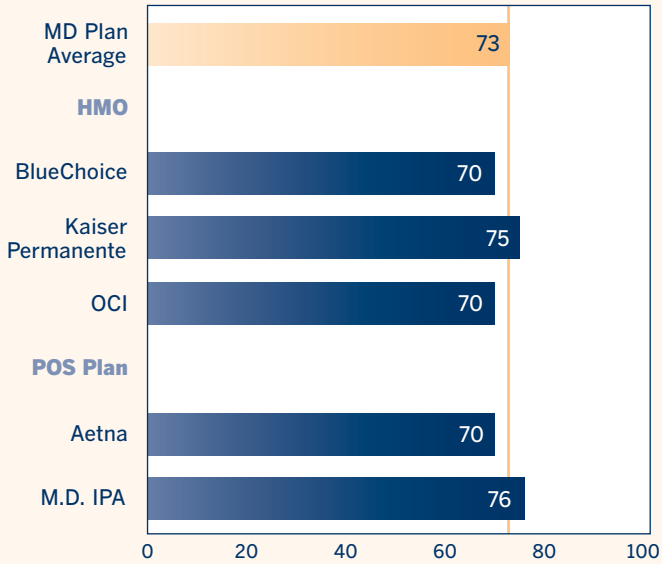
received prenatal care in the first trimester or within 42 days of enrolling in the plan

had a postpartum visit on or between 21 and 56 days after delivery



Screening for Breast Cancer

The percentage of women ages 52–69 who had a mammogram in 2003 or 2004.



MANAGE YOUR HEALTH CARE

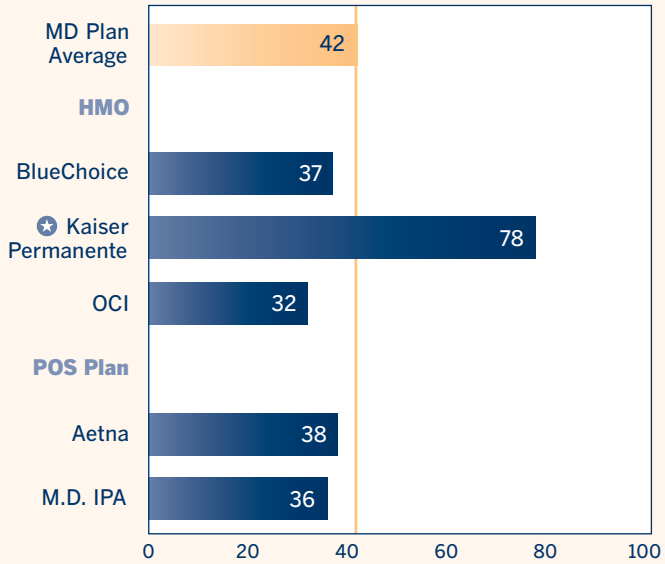
Screening for breast cancer (known as a mammogram) is the best way to detect disease early. Studies show that early detection saves lives. It is recommended that women ages 40–74, or younger if at high risk, get screened every 1 to 2 years (CDC, 2005). The State of Maryland offers screening to low income women as part of its National Breast and Cervical Cancer Early Detection Program. Pass this information to women you may know who have not been screened and may be eligible for this program. For more information check the program's Web site at **www.fha.state.md.us/cancer/html/bc_scrn.html** or call 800-477-9774.

Breast cancer screening rates for Maryland plans have declined in the last 3 years.

✪ **STAR PERFORMER:** The plan's performance was above average for three years in a row.

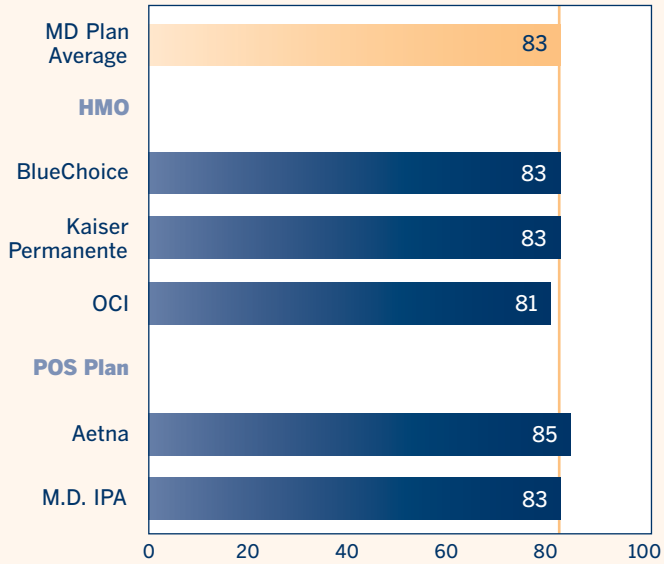
Screening for Chlamydia

The percentage of women ages 16–25 who received a test for chlamydia, a sexually transmitted bacterial infection.



Screening for Cervical Cancer

The percentage of women ages 18–64 who received a Pap test to screen for cervical cancer within the three-year period of 2002–2004.



Adult's Health

SUMMARY

The circles on this page summarize how well plans provided their adult members with important health care services. Bar graphs show plans' scores for each area. Higher than average scores mean better plan performance.*

Health Plan	Controlling High Cholesterol		Persistence of Beta Blocker Treatment After a Heart Attack	Screening for Colorectal Cancer	Appropriate Medicine for Adults With Asthma
	<100 mg/dL	<130 mg/dL			
HMO					
BlueChoice	◓	◓	○	●	●
Kaiser Permanente	●	◓	●	○	○
OCI	●	●	●	○	◓
POS PLAN					
Aetna	◓	○	◓	○	○
M.D. IPA	◓	◓	●	●	◓

See below for averages, individual scores, and descriptions of these measures.

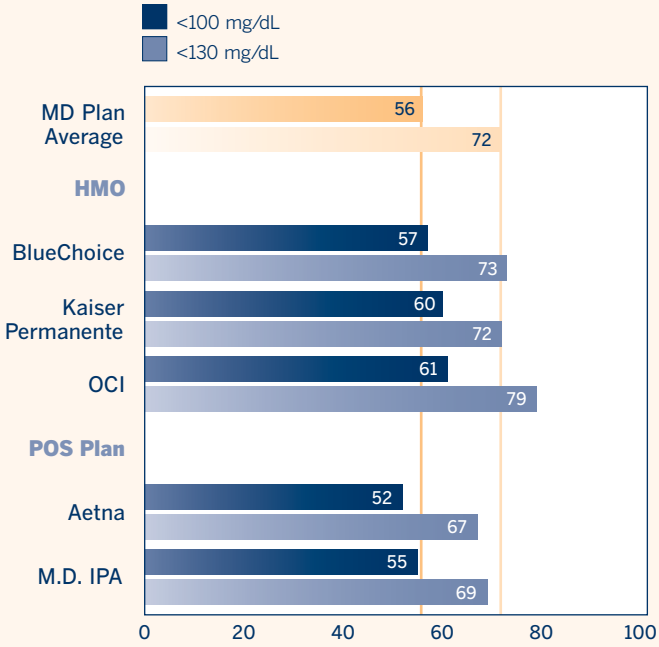
- ● **HIGHER** represents an **Above Average** score
- ◓ **AVERAGE** represents an **Average** score
- ○ **LOWER** represents a **Below Average** score

*Circles show statistically significant differences between each plan's score and the Maryland average. Statistically significant means scores varied by more than could be accounted for by chance.

DETAILS Health Plan Records

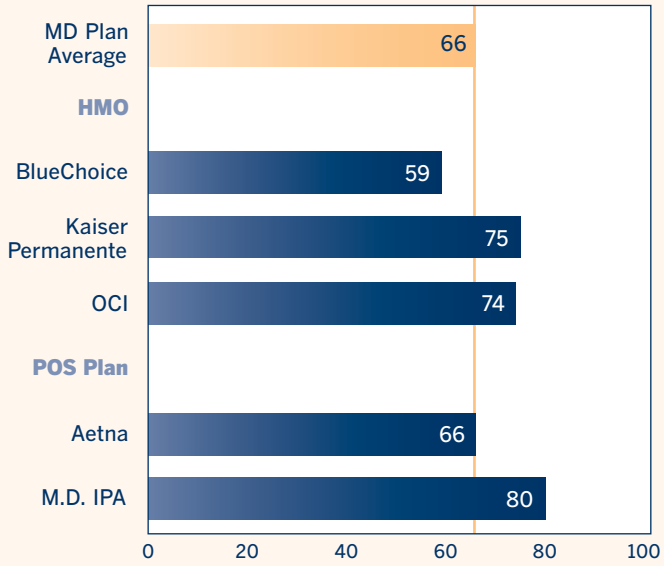
Controlling High Cholesterol

Percentage of members ages 18–75 who had a heart attack and whose cholesterol (LDL-C) level was controlled between 60 and 365 days after discharge:



Persistence of Beta Blocker Treatment After a Heart Attack

The percentage of members ages 35 and older who were hospitalized due to a heart attack and who received a beta blocker medication for 6 months after discharge.



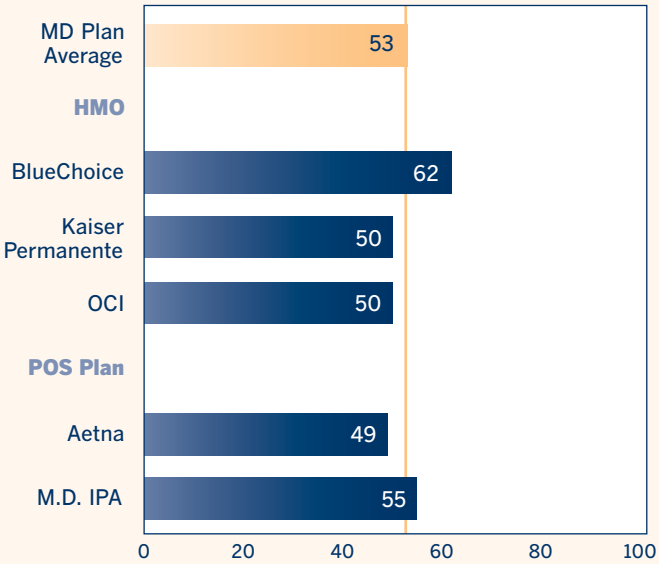
MANAGE YOUR HEALTH CARE

Nearly one in three adults in the United States has high blood pressure (Journal of the American Heart Association, 2004). Most people do not have symptoms; and therefore, do not know that they have it. Uncontrolled high blood pressure can lead to stroke, heart attack, heart failure, or kidney failure. This is why it is often called the "silent killer." The only way to know if you have high blood pressure is to have your blood pressure checked regularly. If you do have high blood pressure, keep your doctor's appointments to monitor it, take your medications, and follow your doctor's advice on diet and exercise.

On average, 66 percent of members in Maryland plans with high blood pressure had it controlled.

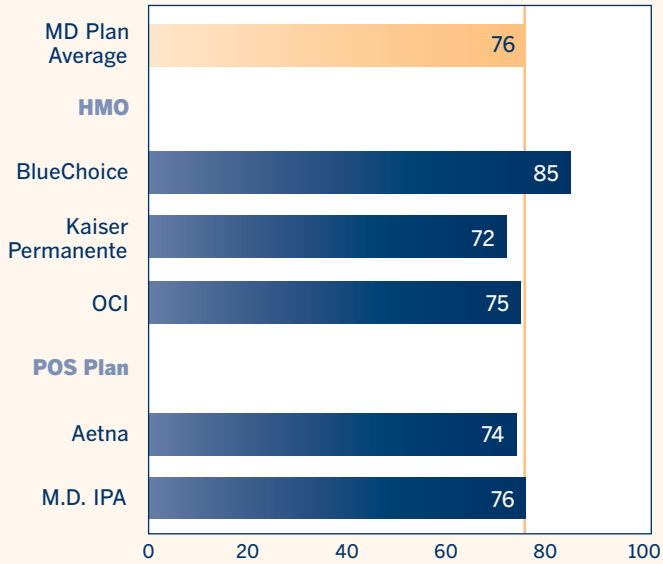
Screening for Colorectal Cancer

The percentage of adults ages 50–80 who received a test that screens for colon cancer.



Appropriate Medicine for Adults With Asthma

The percentage of members ages 18–56 with persistent asthma who received inhaled asthma medicine (corticosteroids or one of three alternative therapies) in 2004.



Diabetes Care

SUMMARY

The circles on this page summarize how well plans provide care for their members with diabetes. Bar graphs show plans' scores for each area. Higher than average scores mean better plan performance.*

Health Plan	Blood Glucose (Sugar) Control	Cholesterol Control		Eye Exams	Monitoring for Kidney Disease (Diabetic Nephropathy)
		<100 mg/dL**	<130 mg/dL		
HMO					
BlueChoice	○	◓	◓	◓	◓
Kaiser Permanente	●	●	●	●	●
OCI	◓	◓	◓	○	○
POS PLAN					
Aetna	◓	○	◓	○	○
M.D. IPA	◓	◓	◓	●	○

See below for averages, individual scores, and descriptions of these measures.

- ● **HIGHER** represents an **Above Average** score
- ◓ **AVERAGE** represents an **Average** score
- ○ **LOWER** represents a **Below Average** score

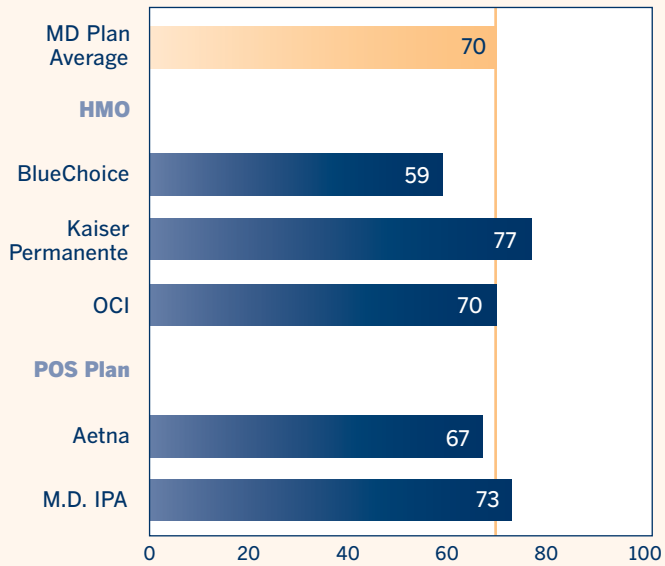
*Circles show statistically significant differences between each plan's score and the Maryland average. Statistically significant means scores varied by more than could be accounted for by chance.

**Based on The American Heart Association recommendation that cholesterol (LDL-C) levels should be <100 mg/dL to ensure good health for people at high risk of heart disease.

DETAILS Health Plan Records

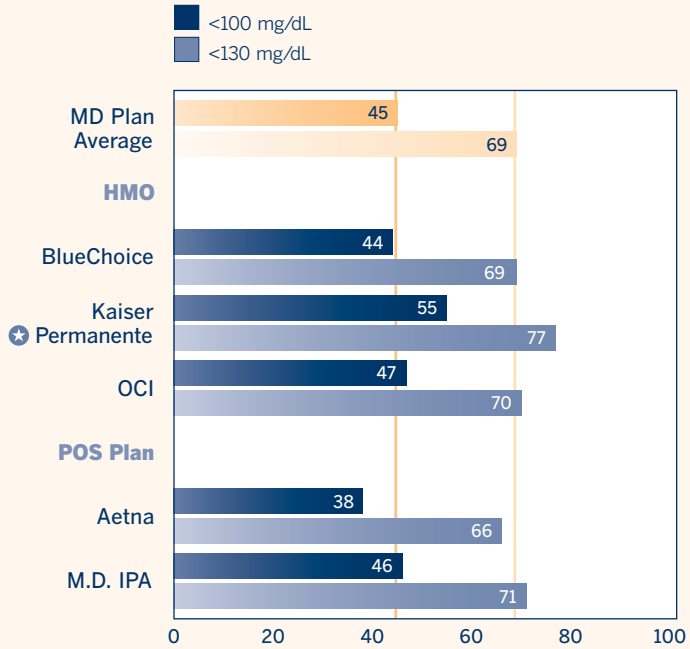
Blood Glucose (Sugar) Control

The percentage of adult members with diabetes whose blood sugar (HbA1c) level is 9% or less.



Cholesterol Control

The percentage of adult members with diabetes whose cholesterol (LDL-C) level is:



MANAGE YOUR HEALTH CARE

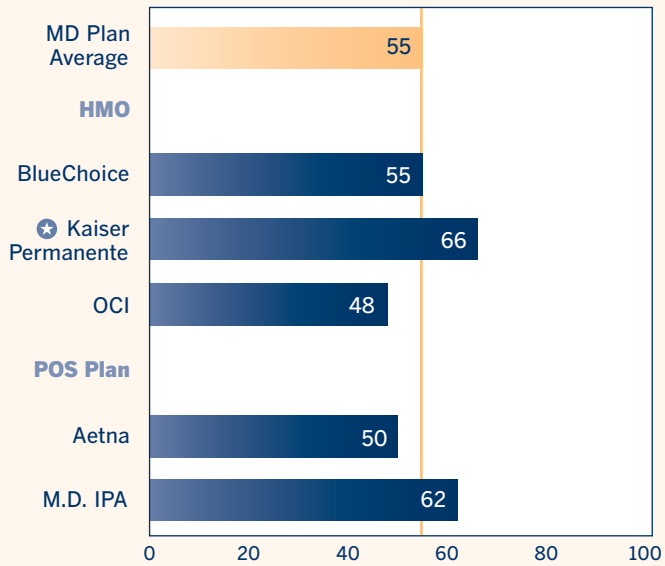
Preventing diabetes is possible, proven, and powerful. Studies show that adults at high risk for diabetes can prevent or delay the disease by losing 5 to 7 percent of their body weight. This can be done by eating healthy foods and getting 30 minutes of physical activity 5 days a week (National Institutes of Health, 2005). This is also good advice for people who already have diabetes. Diabetic patients should see their doctor to get regular check ups, blood sugar and cholesterol levels, eye exams, and tests for kidney disease.

On average, only 21 percent of Maryland plan members received this recommended care and had good blood sugar and cholesterol levels.

✪ **STAR PERFORMER:** The plan's performance was above average for three years in a row.

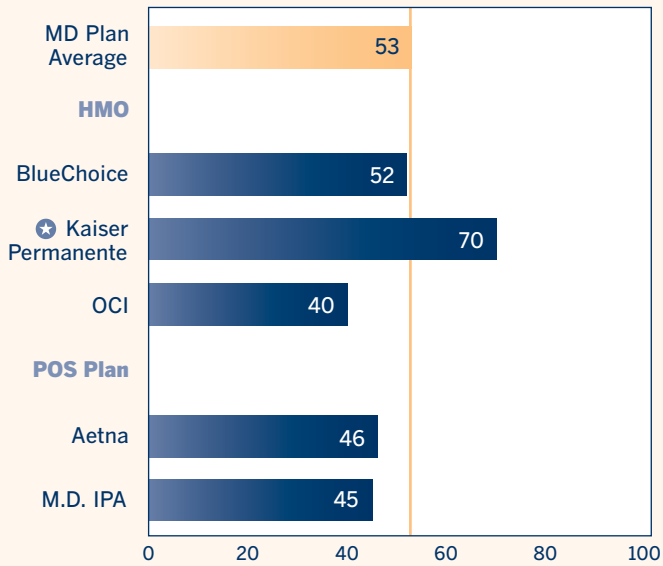
Eye Exams

The percentage of adult members with diabetes who had an eye screening for retinal disease in the past year (or the year prior, if diabetes is controlled).



Monitoring for Kidney Disease (Diabetic Nephropathy)

The percentage of adult members with diabetes who were checked or treated for kidney disease, known as diabetic nephropathy.



Behavioral Health Care

SUMMARY

The circles on this page summarize how well plans provided behavioral health services. Bar graphs show plans' scores for each area. Higher than average scores mean better plan performance.*

Health Plan	Antidepressant Medication Management			Follow-Up After Hospitalization	
	TREATMENT	MONITORING — 3 MONTHS	MONITORING — 6 MONTHS	7 DAYS	30 DAYS
HMO					
BlueChoice	○	●	●	◒	◒
Kaiser Permanente	○	●	●	●	◒
OCI	●	◒	○	◒	◒
POS PLAN					
Aetna	◒	◒	◒	◒	●
M.D. IPA	●	◒	◒	◒	●

See below for averages, individual scores, and descriptions of these measures.

- ● **HIGHER** represents an **Above Average** score
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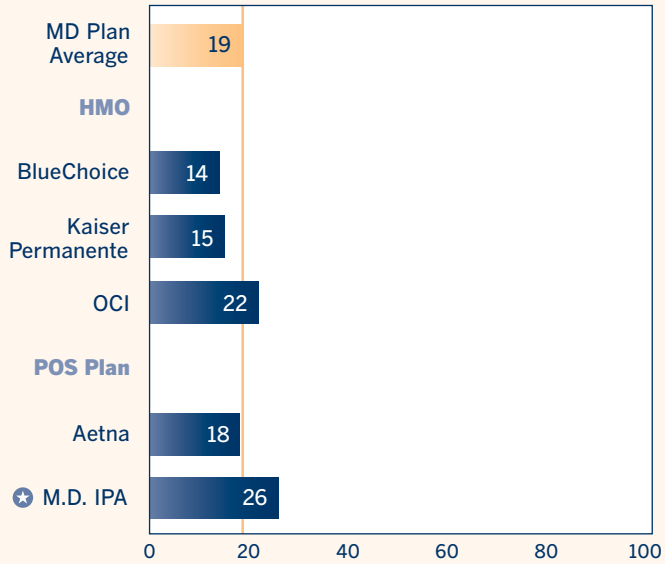
*Circles show statistically significant differences between each plan's score and the Maryland average. Statistically significant means scores varied by more than could be accounted for by chance.

DETAILS Health Plan Records

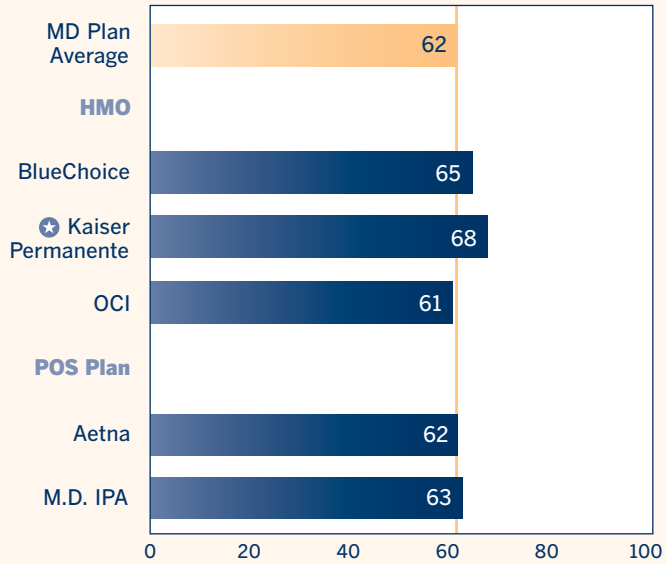
Antidepressant Medication Management Treatment

The percentage of members who saw a primary care physician or mental health practitioner at least three times within the first three months of being diagnosed with depression.



Antidepressant Medication Management Monitoring — 3 Months

The percentage of members who continued taking their antidepressant medication for at least three months.



MANAGE YOUR HEALTH CARE

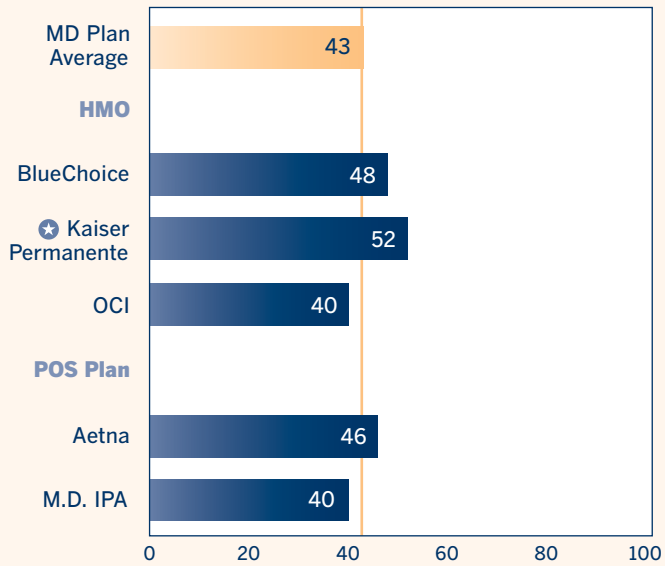
Alcohol and drug abuse can cause health problems such as liver and heart disease, cancer, and stroke (Center for Substance Abuse Prevention, 2005). Getting help for these problems can greatly improve your chances of leading a healthier life. It is important to complete the treatment that your doctor sets for you. Those who stay in treatment longer than three months usually do better than those who stay less time (National Institute on Drug Abuse, 2005).

In 2004, on average, 44 percent of Maryland plan members who had an alcohol and drug abuse problem sought treatment. However, of those who sought treatment only 14 percent continued toward completion of the treatment.

✪ **STAR PERFORMER:** The plan's performance was above average for three years in a row.

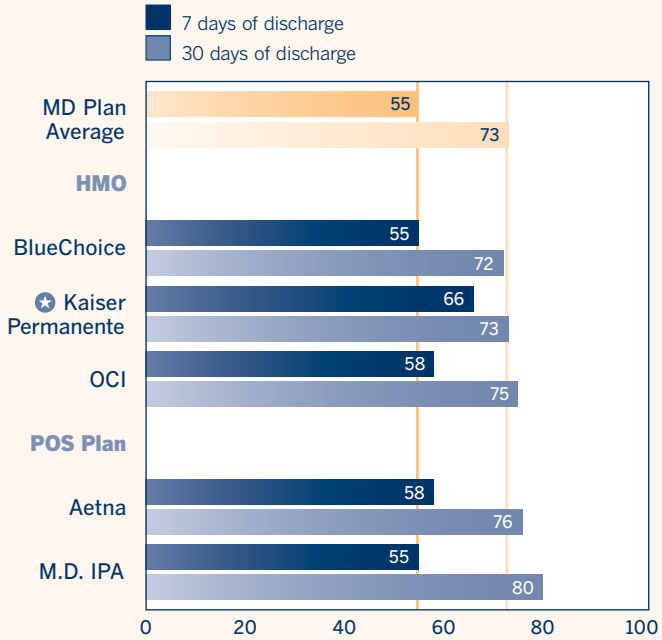
Antidepressant Medication Management Monitoring — 6 Months

The percentage of members who continued taking their antidepressant medication for at least six months.



Follow-Up After Hospitalization

The percentage of members ages 6 and older who were hospitalized for a mental disorder and were seen at least once by a mental health provider within:



Planning Your Health Care

GETTING CARE WHEN YOUR DOCTOR CAN'T SEE YOU

There might be times when you are injured or become ill and your doctor is not available. In some cases an emergency department at a hospital may be the best place to get treatment, but not always. Other than serious injury, most medical problems are more easily diagnosed and treated when a relationship between the patient and the physician exists. The amount you will pay for the visit costs more than seeing your doctor or going to an urgent care center. Also, if you visit the emergency department for a minor problem, you will likely find yourself facing a long and frustrating wait, since patients with more serious problems will receive care first. According to the CDC, patients in 2001 on average, waited 3 hours in the emergency department—from arrival to discharge. Some waited more than 24 hours.

Your doctor or health plan can advise you before you go to the emergency department, if you feel unsure about whether or not you need emergency care. Before a situation like this occurs, ask your plan about:

- how to get care for non-life-threatening conditions after normal business hours;
  - locations, phone numbers, and hours
  - whether a referral from a doctor is needed
- what to do if you need to go to the emergency department; and
- what to do if you are admitted to the hospital as a result of the emergency.

PRESCRIPTION DRUGS

Prescription drug prices are rising fast. Health plans try to keep the amount of money members pay for medications low by choosing which drugs to make available to members and at what cost. The list of prescription drugs that the plan covers is called a **formulary**. Prescription drug coverage is arranged by the State separately from health coverage. This gives State employees the option to choose health coverage only or health and prescription drug coverage.

Formulary policies are reviewed under the pharmaceutical management standards for health plans that choose to be accredited by NCQA to ensure that their drug formularies are fair and valid. *See page 22 for plan accreditation status.*

Most health plan members have to pay a portion of the cost for their prescriptions. Generally, members pay less if they choose **generic drugs** (drugs that do not have a brand name) from the plan's formulary.

Under Maryland's 1999 Patients' Bill of Rights Act, health plan members can get a prescription drug or device that is not on the plan's formulary if:

- no similar drug or device exists; or
- a similar drug or device that is covered by the health plan has been ineffective or could cause harm to the member.

For more information about prescription drug coverage and State employee benefits, refer to the 2006 State of Maryland *Summary of Benefits for Active & Retired Employees*.

OBTAINING AUTHORIZATION FOR BEHAVIORAL HEALTH CARE

Health plans arrange behavioral health care in various ways. Some plans provide the services directly through their own network of behavioral health providers, while others contract with organizations called managed behavioral health care organizations (MBHOs). Behavioral health organizations specialize in mental health care and chemical dependency services.

Prepare for your appointments. Ask whether you need a referral, about limits on coverage, if you can see behavioral health providers outside of the health plan's service area, and your costs, such as copayments.

State Employees Enrolled in POS and PPO Plans
State employees who select a POS (Aetna or M.D. IPA) or PPO plan (CareFirst BlueCross BlueShield PPO or MAMSI MLH-Eagle PPO) receive behavioral health services from APS Healthcare, Inc. The State contracts separately with APS to provide behavioral health services for employees who choose one of these plan options for their health care. If you are enrolled in one of these plans, you should contact APS to obtain authorization for behavioral health services and referrals.

State Employees Enrolled in an HMO Plan
State employees who select an HMO plan (BlueChoice, Kaiser, or OCI) receive behavioral services through either the MBHO network selected by the health plan or directly from the health plan's network of providers. You should contact Kaiser** and OCI directly to obtain authorization for behavioral health services and referrals. State employees enrolled in BlueChoice should contact the plan's MBHO, Magellan at 800-245-7013 for referral and authorization.

The table below compares the number of providers in each network for HMOs only. HMOs must report information about their behavioral health care services to the State. APS is not required to submit performance data to the State, and therefore, information about the APS network available to State employees does not appear in the table below.

Health Plan	Number of Behavioral Health Care Providers as of Spring 2006* (per 1000 Members)			
	Psychiatrists (M.D.)	Psychologists (Ph.D.)	Other Providers	Total Providers
BlueChoice	0.6	0.9	3.5	5.0
Kaiser Permanente**	0.6	0.7	2.7	4.0
OCI	2.0	1.9	4.7	8.6

* Number of providers is based upon the service area of the plan. The MBHO network may have a larger number of practitioners than reported in this Guide.
**During 2006, Kaiser Permanente will transition to an in-house only network of behavioral health providers, except in the Baltimore area. As the network arrangement changes, the rate of APS practitioners per 1,000 members will decrease and the rate of Kaiser practitioners per 1,000 members will increase. When this transition is complete, only plan members whose personal physician is located in Baltimore will continue to receive and have their services administered by APS Healthcare, Inc. For further details, contact Kaiser Permanente.

GETTING CARE WHEN YOU ARE TOO SICK TO COMMUNICATE

An accident or illness can take away your ability to make health care choices. If you are unable to make health care decisions, there are steps you can take beforehand to make sure your wishes are carried out. By creating your own set of instructions through a legal document known as an **advance directive**, you can:

- designate someone you trust to make health care decisions for you; and
- document your treatment wishes, particularly about treatments needed to keep you alive.

These are very important, personal decisions. Making them now enables you to not only care for yourself but those you care about. Below are frequently asked questions about creating your directives.

- **Who can you pick as the person who will make decisions when you cannot?** Anyone who is 18 or older and who is not involved with the health care facility where you are receiving care.
- **Who should get a copy of your advance directive?** Give a copy to your doctor, health care agent, hospital or nursing home, and to the family or friends who should know about your wishes (State of Maryland Office of the Attorney General, 2005).

For more information on advance directives and about your rights under Maryland law go to Maryland's Web site at **www.oag.state.md.us/healthpol/index.htm**.

Getting More Information

INSURANCE COMPLAINTS AND APPEALS

You have the right to disagree with your health plan's decision to deny, limit, or not cover a medical service. You can ask your health plan to change its decision (a **grievance**) and, if you do not agree with the decision, you can ask a government agency to decide if the plan's final decision is fair (a **complaint**). The type of plan you are in makes a difference in what steps you should take. A description of plan types follows.

Fully-Insured Health Plans—State Regulated

Contracts between the State of Maryland and HMOs stipulate that the HMO fully insures all members. The State of Maryland regulates these plans through the Maryland Insurance Administration (MIA); therefore, as a member of BlueChoice, Kaiser Permanente, or OCI you may do the following after exhausting your plan's internal process*:

- challenge a plan's nonpayment of a health care service;
- use a plan's grievance process when payment of a health care service is denied or an adverse decision is made by the plan;
- obtain assistance from the Consumer Protection Division of the Maryland Attorney General's Office (call 877-261-8807) when filing a grievance with the plan;
- receive a grievance decision from a plan within 30 working days of filing, or within 24 hours if it concerns an emergency; and
- if you still disagree with the plan's decision, you can file a complaint in writing with the Maryland Insurance Administration (call 800-492-6116).

Self-Insured Health Plans—Federally Regulated

The State of Maryland is primarily self-insured for members belonging to POS plans in the Guide, *Maryland Point of Service*, administered by BlueCross BlueShield Maryland (not in this Guide), and PPOs offered to State employees. Members of these plans must first exhaust their plan's internal process*. A federal law known as ERISA regulates these plans. You may:

- appeal to the U.S. Department of Labor (866-4-USA-DOL) regarding problems that cannot be resolved with a plan; and
- obtain assistance from a mediator from the Consumer Protection Division of the Maryland Attorney General's Office (call 877-261-8807).

*Members of HMO, POS, and PPO plans having a problem that cannot be resolved through the internal process can send their appeal to the Benefits Review Committee. The committee considers appeals on a monthly basis, for which it has received all documentation from the member's provider and plan. Send appeals to: State of Maryland Benefits Review Committee, c/o Employee Benefits Division, 301 W. Preston Street, Rm 510, Baltimore, MD 21201.

ACCREDITATION AND FINANCIAL RATINGS

Accreditation and Financial Ratings are other ways of assessing health plan quality. Accreditation lets consumers know that an independent organization has checked how well a health plan provides health care. Plans that meet certain standards are accredited. The National Committee for Quality Assurance (NCQA) and the American Accreditation Healthcare Commission (URAC) accredit the health plans in this Guide.

A.M. Best rates the financial strength of health plans. A.M. Best assesses the ability of companies to meet their financial obligations through an evaluation of the company's balance sheets, operating performance, and business profile.

The table below shows the accreditation status and financial rating of each Maryland health plan.

PERFORMANCE REPORTS

For an electronic version of this Guide and additional information on HMO/POS quality and performance visit the MHCC Web site at **http://mhcc.maryland.gov/consumerinfo/**.

- *Measuring the Quality of Maryland HMOs and POS Plans: Consumer Guide.* Contains similar information as the *State Employee Guide*, but covers all seven HMOs and their HMO-linked POS plans operating in the State of Maryland.
- *Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland.* Contains more plan-specific rates on various HEDIS (clinical) and CAHPS® (survey) measures.
- *Maryland Commercial HMOs & POS Plans: Report to Policy Makers.* Compares the performance of commercial HMOs and POS plans in Maryland, as a group, to their counterparts in the region and nation.

Other publications on the performance of health care providers are available on the MHCC Web site at **http://mhcc.maryland.gov/consumerinfo/**, including these three Web-based, interactive Guides:

- *Maryland Hospital Performance Evaluation Guide.* Users can compare the quality of care provided by Maryland hospitals.
- *Maryland Nursing Home Performance Evaluation Guide.* Users can compare comprehensive nursing care facilities and continuing care retirement communities in Maryland on age or functional ability of residents and on measures of quality.
- *Maryland Ambulatory Surgery Facility Consumer Guide.* Users can compare descriptive information about ambulatory surgery facilities and their services.

Health Plan	Accreditation*			Financial Rating**
	Organization	Status	Expiration Date	
HMO				
BlueChoice	NCQA	Excellent	12/07	B+ pd Very Good (A.M. Best ID# 68605)
Kaiser Permanente	NCQA	Excellent	06/07	B++ pd Very Good (A.M. Best ID# 68551)
OCI	NCQA	Excellent	03/09	A Excellent (A.M. Best ID# 68764)
POS				
Aetna	NCQA	Excellent	01/08	A Excellent (A.M. Best ID# 68550)
M.D. IPA	NCQA	Excellent	03/09	A Excellent (A.M. Best ID# 68606)

* Status is current as of March 2006.
NCQA—One of five possible accreditation levels is awarded based on the plan's performance: Excellent, Commendable, Accredited, Provisional, Denied. For current NCQA accreditation status, visit the Web site at **www.ncqa.org**.
URAC—One of three possible accreditation levels is awarded based on the plan's performance: Full, Conditional, Provisional. For current URAC accreditation status, visit the Web site at **www.urac.org**

Ratings are as of March 2006. For current A.M. Best ratings, visit the Web site at **www.ambest.com
Secure Ratings: A++ and A+ Superior, A and A- Excellent, B++ and B+ Very Good
Vulnerable Ratings: B and B- Fair, C++ and C+ Marginal, C and C- Weak, D Poor, E Under Regulatory Supervision, F In Liquidation, S Suspended
Ratings Modifiers: pd= Public Data: rating is based on a review of publicly filed documents only.

How HMOs and POS Plans Work

HMO and POS plans work to keep you healthy. These plans focus on maintaining health. They do this by giving you services that help prevent illness and other problems. You can expect your benefits to cover immunizations, check-ups, and wellness programs. HMOs and POS plans also work to coordinate all of your health care through a **network** of doctors, hospitals, and other providers. Doctors that are not part of a plan's network are called **out-of-network providers**.

This table has the basics of how HMOs and POS plans typically work. **Remember to check with your health plan or employer about the specific rules for your health plan.**

Questions to consider...	HMO	POS
How do I get care?	You receive care from the plan's network of doctors, hospitals, and other health care providers.	You can receive services from in-network and out-of-network providers. For out-of-network care, you often pay more of the costs, known as out-of-pocket expenses.
Do I need to choose a primary care provider (PCP)?	Yes. Your PCP serves as "manager" of your health care. Your PCP ensures that the health care you get is right for you.	You must choose a PCP for all in-network services.
Will the plan pay for services if I see a provider outside of my plan's network?	No. You are responsible for the cost of seeing an out-of-network provider unless your plan gives you approval.	Yes. You may see an out-of-network provider, but you will pay higher out-of-pocket expenses.
Do I need a referral to see a specialist?	You typically must get a referral from your PCP to see most specialists. Some HMO's offer an option called "**Open Access**," which allows you to see specialists in the network without a referral.	You typically must get a referral if you want to see an in-network specialist. You do not need a referral to use an out-of-network specialist.
How much will I pay for office visits and other health services?	An HMO, typically charges a copayment. State employees pay $15 for a PCP office visit and $25 for a specialist office visit. You do not usually need to pay a deductible or file a claim.	In-network: You pay a copayment. State employees pay $15 for a PCP office visit and $25 for a specialist office visit. You do not usually need to pay a deductible or file a claim. Out-of-network: You must pay a deductible ($250 Individual, $500 Family) and coinsurance (usually 20%–40% of the total bill). You may need to file that claim.*

*Any fees above the **allowed amount** are not covered toward the out-of-pocket maximum.

Plan Service Area and Contact Information

Below is a list of the plans in this Guide. Use it to:

- find a plan where you live or work; and
- obtain additional information directly from the plan by using its customer service number or Web site.

Service Area—Counties

Baltimore Metropolitan Area: Baltimore City, Baltimore, Carroll, Harford, Howard, Anne Arundel

Washington D.C. Metropolitan Area: Montgomery and Prince George's

Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester

Southern Maryland: Calvert, Charles, St. Mary's

Western Maryland: Allegany, Frederick, Garrett, Washington

Health Plan	Maryland and Adjacent Services Areas Maryland jurisdictions included in each region are described above					Customer Service Information
	Baltimore Metro Area	Washington D.C. Metro Area	Eastern Shore	Southern Maryland	Western Maryland	
HMO						
BlueChoice	✔	✔	✔	✔	✔	866-520-6099 8:00 am–6:00 pm Monday–Friday 9:00 am–2:00 pm Saturday www.carefirst.com
	Northern Virginia					
Kaiser Permanente	✔	✔		Calvert, Charles	Frederick	800-777-7902 301-468-6000 For the hearing and speech impaired: 301-879-6380 7:30 am–5:30 pm Monday–Friday www.kaiserpermanente.org
	Northern Virginia					
OCI	✔	✔	✔	✔	✔	800-709-7604 24 Hours, 7 Days www.mamsiUnited Healthcare.com
	Washington D.C., Virginia, Delaware, West Virginia					
POS						
Aetna	✔	✔	Cecil, Kent, Queen Anne's Talbot, Wicomico	✔	Frederick, Washington	800-323-9930 8:00 am–6:00 pm Monday–Friday www.aetna.com
	Northern Virginia, Richmond					
M.D.-IPA	✔	✔	✔	✔	✔	800-709-7604 24 Hours, 7 Days www.mamsiUnited Healthcare.com
	Washington D.C., Virginia					

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